DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended POC acceptable 3/15/11 mail. please stip use 3/11/11 ist poc acceptable date

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to complete nail care for one resident (#8) of twenty-six residents reviewed. The findings included: Resident #8 was admitted to the facility on March 22, 2010, with diagnosis including Cellulitis of Leg, Anemia, and Dementia. Observation on February 23, 2011, at 9:15 a.m., in the resident's room revealed the resident's fingernails and toenails were long and jagged. Observation and interview with Charge Nurse #1 on February 23, 2011, at 9:30 a.m., in the resident's room, confirmed the resident's nails were in need of trimming.	F 312	CORRECTIVE ACTION: Resident #8's fingernails/toenails were cut and filed immediately. All personnel involved were immediately in-serviced on Life Care's policy and procedure for fingernail/toenail care to residents on 2/23/11 by the Unit Manager. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents were assessed for long fingernails/toenails on 2/23/11 by the Unit Managers. No other residents were found to be affected. SYSTEMATIC CHANGES: All facility personnel were in-serviced on 02-23-11 and on 03-03-11 on the appropriate procedure and expectations for ADL care by the Unit Manager and the Staff Development Coordinator. MONITORING: Beginning on 2/23/11, Unit Managers and/or Charge Nurses will make daily rounds on first and second shifts to assure compliance. Rounds will continue for three moths and cease on 6/1/11. Beginning on 2/23/11, the DON, ADON, and/or Weekend Manager will assure compliance by making daily rounds on first and second shifts. This will continue for 3 months and cease on 6/1/11. All findings from the rounds will be turned in to the facility's Executive Director and/or Director of Nursing. The Executive Director/Director of Nursing will report findings monthly to the Quality Assurance/Performance Improvement Committee. This information will be reviewed beginning 3/15/11 and cease on 6/14/11, unless there is need of further observation.	4/10/11
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	CORRECTIVE ACTION: Resident #4's lap buddy was applied immediately. All personnel involved were immediately in-serviced on Life Care's policy and procedure to assure resident safety and where to find information regarding safety devices on caregiver's daily care guides on 2/24/11 by the Staff Development Coordinator. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents with lap buddies and all other safety devices were assessed for proper placement of the safety device on 2/24/11. No other residents were found to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer C Solomon, MA,	Executive Director	3/10/11

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 323	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to apply a safety device to prevent falls for one resident (#4) of twenty-six residents reviewed. The findings included: Resident #4 was re-admitted to the facility on July 23, 2010, with diagnoses including Mental Retardation, Acute Respiratory Failure, and Glaucoma. Medical record review revealed following a fall on December 31, 2010, the resident was assessed and a physician's order was obtained for a lap buddy to be applied when the resident was in a wheelchair. Observations on February 22, 2011, at 3:00 p.m., and February 23, 2011, at 8:45 a.m., revealed the resident sitting in a wheelchair with no lap buddy in place. Observation with RN Supervisor #2, on February 24, 2011, in the resident's room, at 10:15 a.m., revealed the resident sitting in a wheelchair with no lap buddy in place. Interview with the RN Supervisor at that time confirmed the resident is to have a lap buddy when up in the wheelchair.	F 323	SYSTEMIC CHANGES: All facility personnel were in-serviced by the Staff Development Coordinator on 2/24/11 and 3/3/11 on identifying residents that have safety devices and where this information is available on the daily care guides. MONITORING: On 2/24/11, Unit Managers and/or Charge Nurses will begin making rounds to monitor daily safety device application on first and second shift. This will continue for 3 months and cease on 6/1/11. Beginning on 2/23/11, the DON, ADON, and/or Weekend Manager will assure compliance by making daily rounds on first and second shifts. This will continue for 3 months and cease on 6/1/11. All findings from the rounds will be turned in to the facility's Executive Director and/or Director of Nursing. The Executive Director/Director of Nursing will report findings monthly to the Quality Assurance/Performance Improvement Committee. This information will be reviewed beginning 3/15/11 and cease on 6/14/11, unless there is need of further observation.	4/10/11
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must	F 500	CORRECTIVE ACTION: On 2/23/11, the Unit Manager for resident #15 contacted the ESRD facility and obtained pertinent information and specific orders related to dialysis treatment. All licensed nurses involved were immediately in-serviced on Life Care's appropriate policy & procedure for ensuring communication with the End Stage Renal Dialysis (ESRD) facilities that provide professional services to facility residents on 2/23/11 by the Unit Manager.	4/10/11

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F 500	Continued From page 2 have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to ensure communication with the End Stage Renal Dialysis (ESRD) facility where resident #15 received outside facility professional services for one (#15)of twenty-six residents reviewed. The findings included: Resident #15 was admitted to the facility on February 2, 2011, with diagnosis including End Stage Renal Disease, Congestive Heart Failure, and Renal Dialysis. Medical record review of the Daily Care Guide revealed the resident received dialysis treatments, away from the facility, on Tuesday, Thursday, and Saturday at 6:30 a.m., and for "NO B/P (blood pressure) in left arm (site of resident's dialysis fistula)."	F 500	RESIDENTS WITH POTENTIAL TO BE AFFECTED: On 2/23/11, the two other residents receiving professional services from the End Stage Renal Dialysis (ESRD) were assessed for proper communication with the ESRD facility. No other residents were found to be affected. SYSTEMIC CHANGES: All licensed nurses were immediately in-serviced on 02-23-11 and on 03-03-11 on Life Care's appropriate policy and procedure for insuring appropriate communication with ESRD facilities by the Unit Manager and the Staff Development Coordinator. MONITORING: On 2/23/11, Unit Managers and/or Charge Nurses will begin conducting daily first shift chart audits to monitor communication with ESRD facilities. This will continue for three months and cease on 6/1/11. Beginning on 2/23/11, the DON, ADON, and/or Weekend Manager will assure compliance by making daily rounds on first and second shifts. This will continue for 3 months and cease on 6/1/11. All findings from the rounds will be turned in to the facility's Executive Director and/or Director of Nursing. The Executive Director/Director of Nursing will report findings monthly to the Quality Assurance/Performance Improvement Committee. This information will be reviewed beginning 3/15/11 and cease on 6/14/11, unless there is need of further observation. policies attached	4/10/11

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F 500	Continued From page 3 Medical record review of a nurse's note dated February 19, 2011 (dialysis treatment day), revealed " ...resident request bandages be removed from left upper arm (dialysis fistula site)... Removed tape from one side and he began bleeding profusely from fistula site. EMS (Emergency Medical Services) called to transport to ER (Emergency Room)". Continued review of the nurses' notes for February 19, 2011, 2200 (10:00 p.m.) revealed the resident was returned to the facility with no new orders. Interview with Charge Nurse #2 at the Cedar Hall nurse's station on February 23, 2011, at 2:08 p.m., revealed Charge Nurse #2 had removed the dressing on February 19, 2011. Interview at this time with Charge Nurse #1, Charge Nurse #2, Charge Nurse #3, and the Cedar Hall Unit Supervisor confirmed the ESRD facility had not sent written/ and or verbal communication concerning the dressing on the resident's fistula site.	F 500		